OVERVIEW: Insights, Projects and Future Work
COMMUNITY HEALTH TRANSFORMATION

The Center for Innovation (CFI) is partnering with the Mayo Clinic Health System (MCHS) and Employee and Community Health (ECH) to create, pilot and implement a population health model that:

+ Re-centers the system on the patient’s needs—clinical and non-medical
+ Delivers coordinated, integrated care at the right time, in the right place, by the right person, in the right way
+ Improves system capacity, flexibility, and resiliency
+ Leverages community and government assets to reduce or remove obstacles to health and long-term wellness for individuals
+ Reduces costs to people and the practice

Building on the body of existing work in the field, guided by the Triple Aim, and informed by CFI’s human-centered design approach, this work contributes to Mayo Clinic’s preparation for the shift towards pay-for-value and accountability for the total cost of care.

Triple Aim:
Improve the health of the population, enhance the patient experience and reduce the per capita cost of care.

EXPERIMENTS

The Family Dinner Project is a Boston-based non-profit that promotes the benefits of families eating together. We partnered with them to host two community dinners in Dodge County, connecting over 50 participants with their 4-week curriculum, which families use to build the habit of family dinnertime.

The Exam Room in a Backpack concept identified supplies and technologies that could make home visits easier. This solution is particularly relevant for high risk patients and is generating interest for pilots around hospital readmission and home visit services provided by the ECH Care Transitions Program.
WHAT WE HAVE DONE TO GET HERE

CFI explored a range of issues related to population health through literature review, insights from other Mayo initiatives, explorative research (including an embedded designer in Austin Clinic), ongoing projects, and almost 40 quick, low-fidelity tests since late 2011. Predominately centered on Mayo Family Clinic Kasson, experiments included:

- **Exam Room in a Backpack**
  What tools might enable and encourage care to be delivered beyond the clinic walls?

- **I Wish My Doctor’s Office...** What are patients’ needs and desires as consumers?

- **Face-to-Face Interpreting**
  What might create more satisfying, effective experiences for underserved groups in the community?

- **Who Needs to See the Patient?**
  How might we enhance team-based care by understanding what a patient needs and who would be most appropriate to meet that need?

- **Sessions Health Coaching**
  How might new ways of connecting with patients support lifestyle and behavior changes?

- **The Family Dinner Project**
  How might a clinic partnership with a non-profit help nurture a grassroots movement that improves health, wellness, and positive choices in the community it serves?

MAYO FAMILY CLINIC KASSON EXPERIMENTS
Who needs to see the patient? Results from a sample of appointments during Summer 2012.

- 29% could have been RN visits
- 71% of visits required NP, PA, or MD level of licensure

BALDWIN FAMILY MEDICINE EXPERIMENTS
How can we best meet our patients’ needs? Results from Optimized Care Team experiments during Q1 2013.

- 16% with an RN visit
- 18% through non visit care
- 66% with an NP / PA / MD visit
- 36%
CURRENT PROJECTS

Early experiments have developed into a coordinated set of projects that involve prototyping transformative concepts targeting systems of care:

**Optimized Care Team** A colocated, multidisciplinary group that works together to meet the needs of a shared team patient panel.

The Optimized Care Team model introduces a new chassis upon which a transformed system can be built. This new model initiates the necessary mindset, process, and infrastructure shifts inside the clinic to change the individual provider-driven practice to a team-based practice to enable all roles to work at their full scope of licensure.

This high-functioning team has the flexibility to deliver patient experiences in a way that meets both the known and the unanticipated needs of every patient efficiently and effectively. In doing so, the Optimized Care Team model creates greater capacity for non-visit care, proactive patient outreach and population health management.

Pay-for-value allows care delivery beyond the traditional visit to become the norm, rather than the exception.

To realize its full potential, the Optimized Care Team needs to collaborate with their patients in more effective and efficient ways and to provide new services addressing a broad range of issues.

“I felt thoroughly cared for because everyone I saw was part of the same team.”

– patient

“I felt like part of a TEAM rather than an individual working on individual responsibilities.”

– staff member

**Patient-centered Care Plan** A unified tool for patients, caregivers, and clinicians to see, make, and act on care decisions together.

As a patient-driven design, Care Plan creates a compelling, interactive experience for patients to partner with their care team and actively engage with their health. Patients and caregivers have a single place to communicate their priority concerns and to understand all aspects of their health. Future iterations of the Patient-centered Care Plan will continuously aggregate data allowing the Optimized Care Team to deliver individualized experiences at a population scale and proactively understand how to best focus care delivery resources.

“It would be nice to have all of my information in one place where me and my doctor can see everything.”

– patient interview, 48, Female

“I would buy a computer just to use this [care plan].”

– patient interview, 54, Female

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**Priority Concerns**

1. Lose 60 pounds by 12/4/13 in time for my Disney trip and birthday.

Get at least 20 minutes (or more) of exercise daily.

Such as taking a walk or riding a bike.

- I am doing this.
- I am not doing this.
- I want to provide custom feedback or ask a question.

2. Increase physical activity to walk 1.5 miles without pain or shortness of breath.

Get a comfortable pair of shoes that support your feet.

By rotating between a pair of shoes you’ll be able to enjoy more physical activity without pain or discomfort.

- I am doing this.
- I am not doing this.
- I want to provide custom feedback or ask a question.
**Wellness Navigators** A volunteer-provided, clinic-embedded service that connects patients with resources to address social determinants of health.

With a focus on total cost of care, it becomes necessary to address concerns related to social determinants of health. As a new role in the Optimized Care Team, **Wellness Navigators connect patients with existing government, non-profit, and community resources**, enabling the clinic to address patient-important concerns affecting their overall health.

**Community Engagement** A clinic-based coordinator facilitates a self-sustaining, grassroots wellness movement with clinic and community champions.

Addressing long-term population health as well as building strong ties to the clinic, the **Community Engagement Coordinator** encourages and supports clinic involvement in the community as well as the creation of the **Community Health Coalition, a self-sustaining network** of citizens actively generating and promoting initiatives to improve the health and wellness of their community. By **influencing behaviors and choices patients make in the 99% of their lives spent outside the clinic**, Community Engagement may improve health and reduce the development of chronic conditions across a population.

In Q4 2012 and Q1 2013 patients choosing to work with Wellness Navigators had an average Total Cost of Care (TCOC) that was 3.7 times higher than the overall Kasson clinic population. This indicates that the Wellness Navigators provide value by connecting higher TCOC patients (largely Medicare/Medicaid) to non-clinic resources to help address their non-medical barriers to health. Follow up analysis will be done to track ongoing TCOC for these patients.

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Dodge Refreshed, patterned on Mayo Clinic Austin's Mower Refreshed work, is the face of community health and wellness in Dodge County.
Accelerating Care Transformation (ACT)

The ACT Initiatives provide a coordinated approach to effectively and comprehensively diffuse in successive waves the deep transformations the system needs—and wants.

A partnership with the Office of Population Management

In February 2013, at the request of MCHS leadership, CFI conducted the Accelerating Care Transformation (ACT) Workshop as the culmination of research to understand the key innovations and initiatives across the Health System. The outcome of the design work leading to the workshop, and the workshop itself, was the ACT Initiatives platform: a model comprised of STEP-STRETCH-LEAP phases, built as the vehicle for transforming Mayo Clinic in the Midwest, Arizona, and Florida to achieve the Mayo Model of Community Care. Following the Mayo Model of Diffusion, an Alpha-Beta approach was proposed to ensure that the components of each phase were fully refined, standardized, and verified prior to diffusion. Diffusion will be systematic and thorough with regional teams cycling through clinics to provide support, training, and localization while ensuring appropriate standardization.

ACT INITIATIVE PHASES: STEP-STRETCH-LEAP

**STEP**

The elements of STEP fit two criteria:
1. They make sense in the current reimbursement environment
2. They are developed enough to effectively pilot beginning summer of 2013.

**STRETCH**

The elements of STRETCH represent a shift toward a pay-for-value reimbursement model as well as project elements that have greater system prerequisites or need further development.

**LEAP**

The elements of LEAP make economic sense in a pay-for-value environment; require more significant prerequisites (particularly IT) and need longer development time prior to piloting.

Complete system transformation to LEAP accompanying the shift to a total cost of care environment
Caring for patients every day
+ The population of patients attributed to a clinic and their TCOC.
+ This population will likely be served by multiple care teams.

Additional services for complex patients
+ 5% of patients account for 45-50% of the TCOC.
+ This subset of the total population typically falls into 3 categories: those with polychronic conditions, frail elderly and under-served.
+ Focusing on engaging this population both inside and outside of the clinic walls.

Engaging with our communities
+ To reduce the TCOC over the long haul prevention is vital.
+ Thinking beyond the clinic to engage the community where they are.
+ Continuing to build relationships with the individual members of the community.

“We need to be thinking — how do we decrease the variation and how do we make sure we have the same functionality or the same competency in all of our sites no matter which door you go in.”

— Brian Whited, MD
February 25th ACT Across Mayo in the Midwest Workshop

DEFINE | ASSESS | STRATIFY | ENGAGE | MANAGE
Once the population served by the clinic has been defined, assessed and stratified we can focus our engagement efforts based on who the patients is and where they are in their life.
WHAT’S IN IT FOR ME?
COMMUNICATING THE BENEFITS OF THE ACT INITIATIVE

Patients
+ You will get care better tailored to your needs.
+ Your individual relationship with your physician will continue.
+ You will also have access and relationships with other key members of the team.
+ Your care team will be able to support your health needs more quickly and in the ways that work best for you.

Mayo Clinic’s focus on fully integrated team-based care will ensure you have access to the best care when you need it. Based on Mayo’s experience and national studies, we know that team-based care helps create the best experiences and health outcomes for patients. Your care team will be a consistent and stable group of primary care providers—including your current physician or NP/PA—nurses, pharmacists, and other experts that are dedicated to building a relationship with you and understanding your particular needs.

Physicians
+ Your day will be better. Really. You will have lower clerical burden, you will be able to treat patients more effectively, and you will go home on time.
+ This won’t happen all at once.
+ This supports the inevitable shift to a TCOC reimbursement environment in as smooth a transition as possible.

Coinciding with the inevitable shift towards a TCOC reimbursement, STEP-STRETCH-LEAP progressively moves towards a fully integrated team-based model that enables the work of the clinic to be more efficiently shared among a team while enhancing relationships and continuity with patients. Policies at the enterprise and regional level, timed to track closely with changes in the external reimbursement environment, will ensure minimal compensation impact.

ACCELERATING CARE TRANSFORMATION TIMELINE
Development and Diffusion steps for a coordinated approach to system-wide transformation are overseen by the Office of Population Health Management (OPHM) to ensure broad and comprehensive adoption of the key elements of the ACT Initiative.

<table>
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<th>DEVELOP ≈ 6 months</th>
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<tr>
<td><strong>Refine</strong></td>
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<td>Refine individual elements as necessary</td>
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<tr>
<td><strong>Limited Implementation in 4-6 sites</strong></td>
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<tr>
<td>Pre-work; creating slack1</td>
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<tr>
<td>Phase in elements</td>
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<tr>
<td><strong>Document</strong></td>
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<td>Document in preparation for limited implementation</td>
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1. “Slack” created through 1) workflow analysis to remove redundancy and waste, 2) efficiencies gained by rollout of new tools, and 3) reviewing vacancies (e.g., physician spots) and hiring allied health staff.
**Allied Health Staff**

+ Your day will be better. You will feel more involved, activated, and less stress.
+ You will connect more directly with patients’ care.
+ You will be able to work more at the top of your licensure.

The change will happen in a fast but controlled way. We will provide support and consistent guidance for you and all other members of the team.

**Clinic Leadership / Business**

+ Your staff will be happier because they are helping patients in a more meaningful way, going home on time, and working more at the top of their licensure.
+ The clinic can provide excellent care and an excellent experience while lowering overall total costs of care.
+ This won’t all happen at once; you will be supported throughout.

Coinciding with the inevitable shift towards a TCOC reimbursement, STEP-STRETCH-LEAP helps clinics build toward this future with a pragmatic, coordinated approach. Policies at the enterprise and regional level, timed to track closely with changes in the external reimbursement environment, will ensure clinics are well positioned to protect margins and thrive in their individual business climate.

**DIFFUSE** ~ 12 months

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<tr>
<th>Evaluate</th>
<th>Document</th>
<th>Train</th>
<th>Communicate</th>
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<tr>
<td>Create final package of elements</td>
<td>Create diffusion materials</td>
<td>Assemble and train regional diffusion teams</td>
<td>Communicate upcoming changes; prepare sites; energize!</td>
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**NW WI**

**SW WI**

**SW MN**

**SE MN**

**ECH**

**ARZ**

**FLA**

**Round 1**

- Regional diffusion teams² cycle through clinics³
- Pre-work creating slack¹
- Phase in elements, certify adoption

**Round 2**

- Phase in elements, certify adoption

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² Diffusion Team will be determined. Would likely include a Diffusionist, LEAN support for workflow analysis, other allied health staff to help train and act as super user, and an informatics person. RN or other allied health staff to help train and act as super user, and an informatics person.

³ Number of clinics in each region or site varies from two to twelve+
FUTURE WORK

Through Q1 2014 we will continue to work intensively with our partners to ensure the ACT initiatives maintain their focus, effectiveness, and connection to the needs of the patient and the institution.

The ACT initiatives provide an unparalleled opportunity for CFI to help assure that the work is implemented across the system thoroughly and comprehensively. While CFI will not be doing the “heavy lifting” of implementation, there are several areas that require further involvement:

1. **Finalizing the content of each phase of the ACT initiatives**
   CFI will continue to partner with the Midwest Office of Population Health Management (OPHM) to ensure that ideas are not “rounded off”; that constructive, aggressive, and rapid transformation continues to be present.

2. **Fully refine through ongoing experiments specific ACT elements**
   Particularly in the STRETCH and LEAP phases, work must be done to refine and prepare projects for piloting. This work will, in most cases, be lead by OPHM.

3. **Supporting OPHM in communicating and iterating the ACT initiatives**
   CFI’s insights and strengths around patient and staff needs and motivations, along with the design skills and perspective to create actionable messages and tools, will help the team pilot and diffuse the projects.

The ACT Initiatives overlap significantly with existing CFI work; through continued partnership with the various stakeholders, CFI can multiply the impact of the work to date.

FUTURE STATE: EXPANDING THE IMPACT OF EVERY CARE TEAM

The Clinic’s Opportunity to Deliver Care within a Transformed System

**EACH DAY**

- **40 patients seen in-clinic** by 3 providers and RN working with an Optimized Care Team to address diagnosis and plans for acute and complex issues.
- **155 patients cared for where they are** by receiving non-visit care, care coordination and Wellness Navigator services from the Optimized Care Team.
- **1500 patients influenced** by using the Care Plan at home and decreased burden through a minimally disruptive medicine approach.
- **4700 patients, family, & caregivers affected** by increased support for making informed decisions and for healthy behaviors encouraged by a Community Engagement wellness movement.

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<th>Mayo Practice</th>
<th>Connected Care</th>
<th>Health &amp; Wellbeing</th>
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<td>Optimized Care Team</td>
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*Conservative impact estimates based on early findings from Optimized Care Team non-visit care data, assumed team panel size of 8,000 patients, prevalence of multiple chronic conditions, and average household size.*
BEYOND ACT

As CFI looks forward, we have identified a range of opportunities to help make significant transformations in how Mayo delivers care in the changing environment. CFI’s recommendations for future investigations and interventions are based on:

+ Insights from current work; observation of patients, staff, and the macro community; competitive contexts.
+ Insights from conducting numerous workshops, retreats, and site research.
+ Reviewing literature on national best practices and research.

Care Management: Multiple Chronic Condition Support

Much has been written about the increase of patients with multiple chronic conditions and about the burden of these conditions on patients and the cost to the health care system and society. We believe there are huge opportunities to investigate and find interventions that positively impact patients with multiple chronic conditions. The benefits of successful transformations in this area might include:

+ Helping reduce the “tiering-up” of patients as they develop comorbidities and associated increased specialist, ED, and hospital utilization.
+ Providing better care and support for patients coping with multiple chronic conditions.
+ Reducing the personal and societal burden associated with the high burden of multiple conditions.

Health System Innovation Support

A number of clinics and hospitals in the health system have shown very strong innovation ‘genes.’ We hypothesize that building an ongoing relationship with a designer would multiply the innovation capacity of these clinics. Having a designer on site 2-4 days a month with another 1-3 days of studio time available could:

+ Act as a catalyst to increase volume, quality, and level of development of innovations from key clinics.
+ Improve satisfaction for key staff.
+ Increase visibility to an important source of alternate, non-Rochester points of view and innovations.

Customizing Care Delivery to Patient Groups

Currently the system treats patients generally the same regardless of cultural or socio-economic background. While the fairness is very desirable, this approach limits our ability to understand and communicate with patients and fully meet their needs. Understanding and connecting with patients will become more important as patients become consumers with choices in how and where they get health care. Through review of existing research, Mayo knowledge (including existing segmentation done by GBS and others), and additional primary research Mayo Clinic can understand the important nuances and differences amongst key patient populations.

DESIGN ROLES

The CFI designers provide strategic/tactical synthesis, ongoing research and insights, experiment design and execution support, metric definition support, and oversight of the patient and staff experience.

CFI Innovation Coordinators provide experiment coordination and oversight, day-to-day refinement and implementation support, and tactical insights around improving the patient and staff experience.

Designers frequently help connect leadership’s strategic vision with the tactical necessities of implementation. Design can help maintain the vision through understanding the big picture as well as the holistic needs of the patient, the needs of the clinic staff, and other tactical considerations that go into making a successful transformation of care delivery. Two closely connected disciplines within CFI, designers and innovation coordinators, will likely be the main collaborators with the overall team in working towards refining, piloting, and diffusing the ACT Initiatives. We envision the Mayo Midwest team or Quality providing overall project management.